DEPARTMENT OF HEALTH AND HOSPITALS

Amendment/Correction of Health Record Request Form

Name	Request Date
Mailing Address	Date of Birth
City/State/Zip	Medicaid ID# or Soc. Sec. #

Identify the Information you want Amended/Corrected

Which information needs to be amended?

Date of information:	Writer of information:

Explain how the information is incorrect/incomplete. What should the information state to be more accurate or complete?
(You may attach any information you have to support your request.)

1)

2)

3)

If you would like this amendment/correction sent to anyone we may have disclosed this information to in the past, please list the name and mailing address of the organization or individual.

Name:_____ Address:_____

I understand that the Department of Health and Hospitals may or may not amend my record based on my request.
I understand that the Department of Health and Hospitals is not permitted to alter the original record.
I understand this request for an amendment will be made part of my permanent record.
I acknowledge that I have read both pages 1 and 2 of this form.

_____ _____
Signature of Individual or Personal Representative Authorized by Law — Date

_____ _____
Signature of Witness (If signed with an "X' or mark) — Date

For DHH Use Only

Date received:

❒ Accepted ❒ Denied ❒ Delayed
If *delayed, date action will be taken:*_____

If **denied**, mark the reason for denial:

❒ PHI was not created by this organization.
❒ PHI is not available to the individual for inspection as permitted by federal law *(e.g., psychotherapy notes).*
❒ PHI is not part of the designated record set.
❒ PHI is accurate and complete.
❒ Other: Specify_____

Comments:

❒ Individual was informed of denial in writing. *(attach copy of notice)*

_____ _____
Signature & Title of Agency Representative — Date

Your Right to Amend Information in Your Record

- You have a right to request amendments/corrections to your information held in DHH files.
- You have a right to have an answer to your request within 30 days. If there are delays in getting you the answer, you will receive a notice in writing. The delay cannot be more than 30 days.
- If you disagree with the answer, you can provide a written statement saying how you would like your record to be changed. DHH will keep this statement with your record.
- DHH may also write an answer to your statement, which will also be placed in your record. You can have a copy of the statement.
- Your statement and the DHH answer will be included when your record is shared.

Your Right to File a Privacy Complaint

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how DHH has used or disclosed information about you. Your benefits will not be affected by any complaints you make. DHH cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful. Your Privacy office contact is:

State of Louisiana
Department of Health and Hospitals

INSERT PROGRAM OFFICE INFORMATION HERE INCLUDING EMAIL ADDRESS

Phone: ( )
E-mail: Privacy-DHH@la.gov